



Comments

ERISA's Full and Fair Review: Access to Appeal-Level Documents During the Course of an Administrative Appeal

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Introduction

FOLLOWING THE COLLAPSE OF Studebaker's pension plan in 1963, Congress enacted the Employee Retirement Income Security Act of 1974 ("ERISA"), a comprehensive national standard designed to protect employee benefits.¹ Among those protected benefits are employer-sponsored welfare plans, including "benefits in the event of sickness, accident, disability, [and] death."² Plan participants and their beneficiaries who allege improper plan administration must first exercise their right to appeal directly to the plan administrator before bringing a case in federal court.³ This appeals process is an integral

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1. See 29 U.S.C. § 1001(a) (2000); see also S. REP. NO. 98-221 (1984) (discussing the first decade of ERISA); JOHN H. LANGBEIN ET AL., PENSION AND EMPLOYEE BENEFIT LAW 72-76 (4th ed. 2006); STEVEN J. SACHER ET AL., EMPLOYEE BENEFITS LAW 5-7 (2d ed. 2000). See generally James A. Wooten, "The Most Glorious Story of Failure in the Business": The Studebaker-Packard Corporation and the Origins of ERISA, 49 BUFF. L. REV. 683 (2001) (arguing that the closure of a Studebaker plant and its underfunded pension plan was a catalyst for federal employee benefit reform).

2. 29 U.S.C. § 1002(1) (defining an "employee welfare benefit plan" as "any plan . . . established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries . . . benefits in the event of sickness, accident, disability, [or] death," among other things); *id.* § 1003(a) (stating that ERISA "shall apply to any employee benefit plan"). But see *id.* § 1003(b) (exempting governmental and church plans from ERISA coverage).

3. See *id.* § 1133(2); ERISA Claims Procedure Rule, 29 C.F.R. § 2560.503-1(h)(1) (2007).

part of the Act, designed to create a system of internal review and administrative remedies.⁴

ERISA statutorily requires that plans give participants a “full and fair review” of an initial claim determination where the participant exercises his right to an administrative appeal.⁵ If the plan denies the appeal, it must provide the participant with the documents relied upon.⁶ The regulations make clear that those documents must be provided upon an adverse determination on appeal.⁷ However, whether appeal-level documents must be provided *during* the course of an appeal remains an open question.

The Eighth, Ninth, and Tenth Circuits have each considered this issue, but none offer a clear rule regarding if, or when, plans must provide participants access to documents during the course of an appeal.⁸ The precedents on point in each circuit are narrowly tailored to the cases’ facts and therefore provide no broadly applicable rule. Each circuit appears to hold differently, depending on whether the appeal denial is found to be based upon a novel theory. They seek to determine whether the plan relies on a novel theory when it denies the appellate claim on different grounds from the original claim denial. As a result of this narrow focus, plan administrators are left to infer the rules from the ambiguous language of the various decisions. None of the three circuits provide a clear general policy to guide plans or a set of rights that participants can rely on.⁹

This Comment argues that a bright-line rule that does not *require* access to documents during the appeal is most efficient and beneficial to the parties. Such a rule is consistent with the Department of Labor’s (“DOL”) intent and avoids complex timing issues that could unnecessarily prolong the administrative process. Adopting this type of

4. See sources cited *supra* note 3.

5. 29 U.S.C. § 1133(2).

6. 29 C.F.R. § 2560.503-1(i)(5).

7. *Id.*

8. See *Metzger v. UNUM Life Ins. Co. of Am.*, 476 F.3d 1161, 1165–68 (10th Cir. 2007); *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 973–74 (9th Cir. 2006); *Abram v. Cargill, Inc.*, 395 F.3d 882, 886 (8th Cir. 2005).

9. See, e.g., *Niles v. Am. Airlines, Inc.*, No. 04-4060, 2007 WL 30607, at *12 (D. Kan. Jan. 3, 2007) (holding that the plan did not violate full and fair review because of the potential for an interminable review process); *Hornback v. N.Y. Times Co. Long Term Disability Plan*, No. 05-00508, 2006 WL 496050, at *10 (N.D. Cal. Mar. 1, 2006) (demonstrating the confusion surrounding the *Abram* holding and its application to cases with slightly different facts); *Harris v. Aetna Life Ins. Co.*, 379 F. Supp. 2d 1366, 1373–74 (N.D. Ga. 2005) (holding that the plan violated full and fair review by not allowing the claimant to respond to appeal-level documents, despite the potential for interminable review process).

bright-line rule would also eliminate the growing confusion created by the conflicting circuit court opinions. However, in the interest of preserving true “full and fair review” within the legislative intent and common-sense meaning of the phrase, there should be some incentive for plan administrators to provide participants access to appeal documents when practical.

The DOL should add a new regulation in its next set of amendments to clarify that the scope of full and fair review does not require access to appeal-level documents during an appeal. This regulation should acknowledge that the best approach is to encourage access by creating an incentive for plans to provide documents without disrupting the careful balance of the competing interests at stake. The regulation should allow plans to avoid liability for violating full and fair review by providing the claimant with access to appeal-level documents at least fifteen days before final determination of the appeal. If the plan does not provide the claimant access to those documents within the fifteen-day buffer, it should face a rebuttable presumption of denying the claimant a full and fair review.¹⁰

Most importantly, the new bright-line rule will clarify the law in an area currently plagued with ambiguity due to the conflicting circuit court opinions. Employer-sponsored welfare plans, including disability, life insurance, and accidental death and dismemberment plans, are too important to be governed by a muddled and inconsistent appeals process. Plans have too much money on the line, and claimants have their own well-being at stake. Even if the varying circuit court decisions have avoided clear conflict by clinging closely to the specific facts of each case, they have left the issue largely unresolved. As long as plans, claimants, lawyers, and the courts perceive the potential for a split in authority or are unclear on the scope of full and fair review, this highly regulated field will be unnecessarily complicated for all parties.

Part I of this Comment explains the background issues and summarizes the “full and fair review” appeals process. Part II looks at the three main circuit court cases at issue. Part III examines the perceived circuit split and the confusion it creates. Part IV addresses the problems that plague the current state of the law. Part V proposes a new regulation to resolve the issues associated with the appeal-level

10. The remedy for denial of full and fair review is beyond the scope of this Comment. See generally *Elliot v. Metro. Life Ins. Co.*, 473 F.3d 613, 621–23 (6th Cir. 2006) (discussing different circuit court remedies for denying full and fair review, including awarding benefits and remanding to the plan administrator).

reports. Finally, Part VI discusses the potential benefits of the proposed regulatory amendment.

I. The Appeals Process: Full and Fair Review

ERISA procedures require that plans provide an appeals process when a claim for benefits is denied.¹¹ In most situations, plan participants must appeal the initial claim denial, thereby exhausting their administrative remedies, before bringing a suit in federal court to challenge the denial.¹² The plan participant has the right to a “full and fair review” of his or her claim during the appeals process.¹³

ERISA requires that plans “afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.”¹⁴ The regulations set out in some detail what “full and fair review” requires.¹⁵ In the context of an appeal, “a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits.”¹⁶

The regulations then focus on defining what a relevant document is, rather than determining at what point of an appeals process a participant will have access to it.¹⁷ The focus appears to be entirely on documents relied upon in the original claim determination prior to the appeal and appeal-level documents after the appeal.¹⁸ By concentrating only on the question of document relevance at the point of denial, the DOL fails to address the issue of whether a participant has

11. See 29 U.S.C. § 1133(2) (2000); ERISA Claims Procedure Rule, 29 C.F.R. § 2560.503-1(h)(1) (2007).

12. See *Amato v. Bernard*, 618 F.2d 559, 567–68 (9th Cir. 1980) (holding that the Secretary of Labor’s promulgation of 29 C.F.R. § 2560.503-1 demonstrates the Department’s intent to require exhaustion of administrative remedies in most cases); see also *LaRue v. DeWolff, Boberg & Associates, Inc.*, 128 S. Ct. 1020, 1027 (2008) (Roberts, C.J., concurring) (stating that most circuits have found the exhaustion of administrative remedies requirement, but leaving the issue unsettled); *Fallick v. Nationwide Mut. Ins. Co.*, 162 F.3d 410, 418 n.4 (6th Cir. 1998) (listing numerous circuit court decisions finding a requirement that the participant exhaust administrative remedies).

13. 29 U.S.C. § 1133(2).

14. *Id.*

15. 29 C.F.R. § 2560.503-1(h).

16. *Id.* § 2560.503(h)(2)(iii).

17. See *id.* § 2560.503-1(m)(8) (defining relevant documents).

18. See *id.* § 2560.503-1(m)(8)(i) (noting that a document is relevant if it “[w]as relied upon in making the benefit determination”); *id.* § 2560.503-1(i)(5) (providing document access upon an adverse determination on review).

access to appeal-level documents *during* the appeal. As a consequence, timing issues are not regulated with sufficient precision.

The regulations that do address timing issues fail to clarify a plan's obligation to provide access to documents during the course of an appeal. The only regulation that directly addresses the issue of access to documents created during the review states: "In the case of an adverse benefit determination on review, the plan administrator shall provide such access to, and copies of, documents, records, and other information [relied upon]" ¹⁹ Of course, this only applies to access *after* the appeal has been completed since it applies only to an adverse determination. Whether or not a participant is to have access during the appeal is left unclear.

The central timing requirement for welfare plans states that "the plan administrator shall notify a claimant . . . of the plan's benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's request for review by the plan," which creates a general sixty-day framework for appeals. ²⁰ This explicit time limit defining the outer reaches of what is reasonable for the length of an appeals process is crucial for the participant, who presumably wants a determination made as quickly as possible and within a predictable time frame. However, access to appeal-level documents during the course of an appeal may threaten this sixty-day limit and therefore undermine the regulation's intended protection for plan participants. ²¹

II. The Cases

The Eighth, Ninth, and Tenth Circuits have all ruled on a participant's right to access to appeal-level documents during the course of an appeal. ²² The Eighth and Ninth Circuits held that the plan must provide the participant access, ²³ while the Tenth Circuit held that the plan is *not* required to provide access. ²⁴ However, the differing facts of

19. *Id.* § 2560.503-1(i)(5).

20. *Id.* § 2560.503-1(i)(1)(i). *But see id.* § 2560.503-1(i)(2)(i) (creating a special seventy-two-hour review process for urgent claims); *id.* § 2560.503-1(i)(3)(i) (shortening the appeal process to forty-five days for disability claims).

21. See discussion *infra* Part IV.A.

22. *Metzger v. UNUM Life Ins. Co. of Am.*, 476 F.3d 1161 (10th Cir. 2007); *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 973–74 (9th Cir. 2006); *Abram v. Cargill, Inc.*, 395 F.3d 882 (8th Cir. 2005).

23. *Abram*, 395 F.3d at 886; *Abatie*, 458 F.3d at 974.

24. *Metzger*, 476 F.3d at 1167.

each case and the careful language of each holding have done more to confuse the issue than to resolve it.²⁵

A. The Eighth Circuit Requires Access to Appeal-Level Documents During the Course of an Appeal if the Plan Relies on New Information

In *Abram v. Cargill, Inc.*,²⁶ the plaintiff and plan participant Abram lost her appeal of the denial of her long-term disability claim.²⁷ Abram claimed she could not work the required forty hours per week due to fatigue caused by Post-Polio Syndrome, and her doctor supported this claim by concluding that she was disabled.²⁸ The plan administrator denied Abram's claim based on a determination by an independent physician that Abram was capable of performing her mostly sedentary work duties and that her obesity and depression caused the fatigue.²⁹

Abram then appealed the denial and underwent a functional capacity evaluation ("FCE") to substantiate her claim of disabling fatigue.³⁰ The FCE results were sent to the independent physician, who in turn provided a second report to the plan administrator.³¹ This second opinion from the physician determined that the FCE was inconclusive because it tested her based only on a six-hour work day.³² The physician found that if Abram was capable of performing her duties during the six-hour tests, there was no reason to believe she could not perform them for the full eight-hour workday.³³ Based on this opinion, the plan administrator denied Abram's appeal.³⁴ Abram was not provided with the crucial second report from the independent examiner until her appeal was denied.³⁵

25. See Elizabeth J. Bondurant & Ronald Dean, *Update on ERISA Litigation*, SL099 A.L.I.-A.B.A. 81, 122-24 (2006) (reviewing recent full and fair review cases); Mala M. Rafik, *ERISA Updates—The Year in Review*, 2 Ann. 2007 A.A.J.-C.L.E. 1687 (2007) (same).

26. 395 F.3d 882 (8th Cir. 2005).

27. *Id.* at 885.

28. *Id.* at 883-85.

29. *Id.* at 884-85.

30. *Id.* at 885.

31. *Id.*

32. *Id.*

33. *Id.*

34. *Id.*

35. *Id.*

The Eighth Circuit found that the plan did not provide Abram the required full and fair review in her appeal.³⁶ The plan failed to comply because:

Abram was not provided access to the second report by [the independent physician] that served as the basis for the Plan's denial of benefits until after the Plan's decision. Without knowing what "inconsistencies" the Plan was attempting to resolve or having access to the report the Plan relied on, Abram could not meaningfully participate in the appeals process.³⁷

Thus, the court held that Abram could only have been provided a full and fair review of her claim if she had access to the appeal-level report created by the plan's medical consultant *before* the plan's final determination on her appeal.³⁸ The court explained that access was required in this case:

There can hardly be a meaningful dialogue between the claimant and the Plan administrators if evidence is revealed only after a final decision. A claimant is caught off guard when new information used by the appeals committee emerges only with the final denial. Abram should have been permitted to review and respond to the report by [the independent physician].³⁹

Taken at face value, the court's decision appears to hold that full and fair review requires that the plan participant have access to appeal-level reports during the course of the appeal, at least if the plan relies on undisclosed evidence discovered during the appeal.⁴⁰ This policy guarantees that the participant will have the chance to view the documents during the appeals process and therefore presumably have the opportunity for a full and fair review. The next appellate court to undertake this issue, with slightly different facts, came to the same conclusion.

B. The Ninth Circuit Requires Access to Appeal-Level Documents During the Course of an Appeal if the Plan Relies on an Additional Ground for Denial

1. The Case

In *Abatie v. Alta Health & Life Ins. Co.*,⁴¹ Dr. Abatie contracted non-Hodgkin's lymphoma, had to leave his job, and then went on dis-

36. *Id.* at 886.

37. *Id.*

38. *Id.*

39. *Id.* (citation omitted).

40. *Id.*

41. *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955 (9th Cir. 2006).

ability for the final seven years of his life.⁴² When he died in 2000, the beneficiaries under his employer-sponsored life insurance plan filed a claim for their benefits.⁴³ Alta, the insurance company, denied the claim because Dr. Abatie had failed to submit proof of his "total" disability to the plan administrator within twelve months of becoming disabled, as the plan required.⁴⁴ Alta again denied the claim after Dr. Abatie's beneficiaries appealed the decision.⁴⁵ However, Alta added a new reason for denying the claim, stating there was insufficient evidence that Dr. Abatie remained "totally" disabled from the time he left work until his death.⁴⁶

The Ninth Circuit found that this appeal-level "tacking on" of a new reason for denying the participant's claim violated the requirement of a full and fair review.⁴⁷ The court held that "an administrator that adds, in its final decision, a new reason for denial, a maneuver that has the effect of insulating the rationale from review, contravenes the purpose of ERISA."⁴⁸ The holding was based on an interpretation of the full and fair review section of ERISA,⁴⁹ which the court determined "suggests that the specific reasons provided must be reviewed at the administrative level."⁵⁰

2. Reconciling *Abram* and *Abatie*

Abram and *Abatie* are similar in many ways, but the issue presented in each case is slightly different. In *Abram*, the insurance company changed its reason for denying the claim on review.⁵¹ The original denial was based on the participant's depression, but the plan based its final denial on appeal on the inconclusive results of an FCE.⁵² In *Abatie*, the Ninth Circuit opened the door somewhat wider in holding that a full and fair review may require appellate-level access not only when the plan switches to an entirely novel theory, but also when the plan merely adds a new theory to that of the original denial.⁵³ Just how far-reaching the Ninth Circuit intended its holding to be is un-

42. *Id.* at 959–60.

43. *Id.* at 960.

44. *Id.*

45. *Id.* at 961.

46. *Id.*

47. *Id.* at 974.

48. *Id.*

49. 29 U.S.C. § 1133(2) (2000).

50. *Abatie*, 458 F.3d at 974.

51. *Abram v. Cargill, Inc.*, 395 F.3d 882, 885 (8th Cir. 2005).

52. *Id.* at 884–85.

53. *Abatie*, 458 F.3d at 974.

clear. There is nothing to explicitly limit the Ninth Circuit's rule to the "tacking on" situation presented by the facts of the *Abatie* case, leaving open the possibility that the court intended to cover access to all appellate-level documents regardless of any novel theory on review.

However, the facts in *Abram* and *Abatie*, along with the language used in both opinions, suggest a narrower and more nuanced precedent that does not cover all appeal-level documents. More importantly, neither case satisfactorily addresses the complex balancing of the interests and timing issues at stake in the ERISA appeals process. Nor does either case provide clear guidance in creating a general policy to ensure participants are provided the requisite full and fair review in the future. In *Metzger v. UNUM Life Insurance Co. of America*,⁵⁴ however, the Tenth Circuit grappled with some of the questions left unanswered by the Eighth and Ninth Circuits.

C. The Tenth Circuit Does Not Require Access to Appeal-Level Documents During the Course of an Appeal, at Least When the Plan Does Not Rely on a Novel Ground

1. The Case and Its Flawed Holding

In *Metzger v. UNUM Life Insurance Co. of America*, the plaintiff claimed her employer-sponsored disability benefits by citing a number of conditions that she argued rendered her unable to work.⁵⁵ The defendant plan denied her claim based on the report of a medical consultant, who found she was neither under the regular care of a doctor nor was she "totally disabled" as defined by the plan.⁵⁶

When Metzger appealed, the plan sent her files to two medical professionals not involved in the original denial in order to review her claim and determine if the plan's denial was warranted.⁵⁷ Both medical professionals returned reports confirming the validity of the denial.⁵⁸ The plan did not provide Metzger access to these appeal-level documents until after denying the appeal because "they contained no new factual information and recommended denial on the same grounds as the initial claim determination."⁵⁹

54. 476 F.3d 1161 (10th Cir. 2007).

55. *Id.* at 1162–63.

56. *See id.* at 1163.

57. *Id.*

58. *Id.*

59. *Id.*

Unlike *Abram* and *Abatie*, the *Metzger* court held that full and fair review did not require that the plan participant have access to the appeal-level documents during the course of her review.⁶⁰ Furthermore, the court used sweeping language to indicate a broad scope for the case's precedent. The court held that "subsection (h)(2)(iii) does not require a plan administrator to provide a claimant with access to the medical opinion reports of appeal-level reviewers prior to a final decision on appeal."⁶¹ The court went on to state that full and fair review only requires the plan to furnish relevant documents to the participant at the outset and conclusion of an appeal.⁶²

However, the court was careful to distinguish itself from the other circuits by emphasizing the factual differences between the *Metzger* case and the *Abram* and *Abatie* cases.⁶³ Unlike those cases, the plan in *Metzger* denied the participant's appeal on the same grounds as in the original determination.⁶⁴ The court seemingly ignores this point until one crucial sentence that immediately follows the announcement of its holding: "So long as appeal-level reports analyze evidence already known to the claimant and contain no new factual information or novel diagnoses, this two-phase disclosure [at the outset and conclusion of the appeal] is consistent with 'full and fair review.'"⁶⁵ This sentence undermines the broader precedential value of the court's holding by failing to consider what rule would apply where the appeal-level reports do contain new factual information or novel diagnoses. Thus, although the court initially painted its holding with a broad brush, it fails to clarify the law in any situation but the one it was presented with.⁶⁶

60. *Id.* at 1167.

61. *Id.*

62. *Id.* (citation omitted).

63. *Id.*

64. *Id.* at 1163.

65. *Id.* at 1167.

66. *See, e.g.,* *Skipp v. Hartford Life Ins. Co.*, No. 06-2199, 2008 WL 346107, at *10-11 (D. Md. Feb. 6, 2008) (characterizing the *Metzger* decision as a bright-line rule against requiring access, but then confusing matters by concluding that "[t]here was nothing in [the appeal-level] report that would have caught [the participant] off guard"). *But see, e.g.,* *Forrester v. Metro. Life Ins. Co.*, No. 04-1204, 2005 WL 3429542, at *14 (D. Kan. Dec. 8, 2005), *aff'd*, 232 F. App'x 758 (10th Cir. 2007) (relying on *Metzger* and holding that "there is no obligation in the regulations or elsewhere for the proposition that the claimant essentially has a right to immediate production and right to rebuttal to additional medical records and opinions generated *after* the initial denial of claim and prior to any resolution of the appeal").

2. The Effect of the Amended Regulations

The *Metzger* court grounded its holding in an interpretation of new regulatory amendments.⁶⁷ Prior to the amendments, the Code of Federal Regulations ("CFR") required only that a plan participant be able to "[r]eview pertinent documents."⁶⁸ As amended in 2000, the regulations attempt to specify which documents are pertinent (or, as the amended version calls them, "relevant") to an appeal. The CFR's language, however, does not clearly identify when a participant should be granted access to appeal-level documents during the appeals process. The most relevant regulation states that the plan must ensure "that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits."⁶⁹ The CFR does define relevance, but apparently only in the context of documents the plan must provide at the outset and conclusion of an appeal.⁷⁰ As the *Metzger* court notes, the language does not directly address documents created during the appeals process.⁷¹

The *Metzger* court relied upon the DOL's motives for the amendment to justify its regulatory interpretation.⁷² The DOL states that section (m)(8) was adopted to provide claimants with "adequate access to the information necessary to determine whether to pursue further appeal."⁷³ This suggests that the documents are to be provided at the end of the appeal process so that the plan participant has the requisite information to determine whether or not to bring a case in federal district court.

Perhaps the most important aspect of the *Metzger* court's reasoning is that it did not find the *Abram* decision convincing because the *Abram* court did not consider "circularity of review,"⁷⁴ a concept referring to an endless cycle of plans furnishing documents, participants rebutting those documents with their own documents, and the pro-

67. *Metzger*, 476 F.3d at 1166.

68. ERISA Claims Procedure Rule, 29 C.F.R. § 2560.503-1(g)(1)(ii) (1999).

69. ERISA Claims Procedure Rule, 29 C.F.R. § 2560.503-1(h)(2)(iii) (2007).

70. *See id.* § 2560.503-1(m)(8) (defining "relevant documents" as "[documents] submitted, considered, or generated in the course of making the benefit determination," among other things).

71. *Metzger*, 476 F.3d at 1166.

72. *Id.* at 1167.

73. ERISA Claims Procedure, 65 Fed. Reg. 70,246, 70,252 (Nov. 21, 2000) (codified at 29 C.F.R. pt. 2560).

74. *Metzger*, 476 F.3d at 1167 n.3.

cess repeating itself *ad infinitum*.⁷⁵ The *Metzger* court was worried that requiring appeal-level access would create an endless loop of document production and responses, thereby threatening the important time limitations on administrative review and increasing the cost of the appeals process.⁷⁶

The *Metzger* court stated that the *Abram* court did not consider circularity of review because the decision was based on pre-amendment regulations.⁷⁷ Curiously, the *Metzger* court did not explain why the plan and participant would face the prospect of getting trapped in an administrative cycle under the amended code, but would not face that danger under the previous code.

The *Metzger* court appears to have relied on the addition of C.F.R. § 2560.503-1(h)(3)(iii) as the crucial distinction between the amended and previous codes.⁷⁸ The regulation requires plans to consult with appropriate medical professionals to determine the validity of a participant's appeal.⁷⁹ The *Metzger* court interpreted the regulation as requiring the plan to consult a medical professional to address a participant's rebuttal to appeal-level documents.⁸⁰ The court determined that the cost of such a consultation would be a substantial detriment to the plan and that the time it would take for such consultation would be a substantial detriment to the participant, with both being contrary to statutory and regulatory intent.⁸¹ Even in the situation presented by the *Metzger* case, where there are no new facts or novel diagnoses determining the appeal, access to appeal-level documents has the potential to seriously disrupt the administrative process by requiring costly, time-consuming, and ultimately pointless medical consultations.⁸²

75. *Id.* at 1166 ("[I]f read according to plaintiff's view, the regulations set up an endless loop of opinions rendered under (h)(3)(iii), followed by rebuttal from plaintiff's experts, followed by more opinions under (h)(3)(iii), and so on.").

76. *Id.* at 1166-67.

77. *Id.* at 1167 n.3.

78. *Id.* at 1166.

79. ERISA Claims Procedure Rule, 29 C.F.R. § 2560.503-1(h)(3)(iii) (2007).

80. *Metzger*, 476 F.3d at 1166.

81. *Id.* at 1166-67.

82. *Id.*

III. The Ambiguous Circuit Court Decisions Leave the Law Unsettled

All three circuit court decisions appear to limit their holdings to the nuanced facts each case presented.⁸³ As a result, there is no general consensus on how to handle access to documents during an appeal.⁸⁴

A. The Eighth and Tenth Circuits: The Crucial Distinction Between Whether or Not the Plan Relies on a Novel Ground

The Eighth Circuit found that the plan denied the participant a full and fair review by not providing document access during the appeal, but the Tenth Circuit did not.⁸⁵ However, the cases' facts are different enough to question whether or not the decisions create a circuit split. A subsequent district court case in the Eighth Circuit sheds some light on how courts view the conflict.⁸⁶

1. Despite Reaching Opposite Conclusions, the Two Decisions Do Not Create a Clear Conflict

The Eighth Circuit in *Abram* held that when a plan relies on a novel diagnosis to deny an appeal, the participant has a right to the newly relied-upon documents before the appeal is denied.⁸⁷ This provides the participant with the chance to rebut the new opinion and therefore the opportunity for full and fair review.⁸⁸ The Tenth Circuit in *Metzger*, however, held that when a plan relies upon a report that, while new, does not contain any novel diagnoses, the plan participant does not have a right to those documents before the appeal is denied.⁸⁹ According to that court, full and fair review does not require

83. *Id.* at 1167; *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 974 (9th Cir. 2006); *Abram v. Cargill, Inc.*, 395 F.3d 882, 886 (8th Cir. 2005).

84. *See* *Hall v. Metro. Life Ins. Co.*, 259 F. App'x 589, 593–94 (4th Cir. 2007) (holding that a participant is entitled to a full and fair review of only the initial grounds for denial, even if the appeal is denied on a different ground); *Robinson v. Aetna Life Ins. Co.*, 443 F.3d 389, 393 (5th Cir. 2006) (holding that a participant is entitled to review of the specific grounds for a benefits denial, and therefore a plan violates the participant's right to a full and fair review if it denies an appeal on a novel ground without first notifying the participant).

85. *Abram*, 395 F.3d at 886; *Metzger*, 476 F.3d at 1167.

86. *See* *Lammers v. Am. Express Long Term Disability Benefit Plan*, No. 06-CV-1099, 2007 WL 2247594 (D. Minn. Aug. 2, 2007).

87. *Abram*, 395 F.3d at 886.

88. *Id.*

89. *Metzger*, 476 F.3d at 1167.

access to the appeal-level documents in this situation because the plan is relying on the same theory as in the claim's original denial.⁹⁰

These holdings as described above are actually consistent with each other. In declining to follow *Abram*, the *Metzger* court believed *Abram*'s holding to be "that full and fair review requires an administrator to make appeal-level consultants' reports available to claimants during the course of an appeal."⁹¹ The court read *Abram* as creating a bright-line rule requiring that plan administrators provide participants with appeal-level reports solicited by the plan from a medical consultant during an appeal.⁹² The Tenth Circuit nevertheless did not believe it was contravening the *Abram* holding because it relied on the amended regulations that were not applied in the Eighth Circuit's analysis in *Abram*.⁹³

But *Metzger*'s reading of *Abram* is just one possible interpretation, and, by all evidence, not the correct one.⁹⁴ In *Abram*, the defendant relied upon new evidence gathered from the participant's FCE as grounds for denying her appeal.⁹⁵ The court underscored the inconsistency between the plan's original and appeal-level denials, and rationalized its decision by explaining its fear that plans may hold their cards until forced to put them on the table.⁹⁶ The court emphasized that "[a] claimant is caught off guard when new information used by the appeals committee emerges only with the final denial."⁹⁷ Thus, there is little, if anything, in the opinion to suggest that the court's interpretation of full and fair review is as expansive as the *Metzger* court insinuates. Rather, it appears that the *Abram* court limited its holding to situations where the plan relies on a novel piece of evidence or diagnosis to deny an appeal.

2. A District Court in the Eighth Circuit Sides with *Abram*

In *Lammers v. American Express Long Term Disability Benefit Plan*,⁹⁸ the plan relied on an appeal-level opinion from an independent medi-

90. *Id.*

91. *Id.* at 1167 n.3.

92. *Id.*

93. *Id.*

94. See *Abram v. Cargill, Inc.*, 395 F.3d 882, 886 (8th Cir. 2005) (appearing to limit its holding, which found a denial of full and fair review, to situations where the plan relies on a novel ground on review).

95. *Id.* at 885.

96. See *id.* at 886.

97. *Id.*

98. No. 06-CV-1099, 2007 WL 2247594 (D. Minn. Aug. 2, 2007).

cal examiner (finding that the claimant was capable of working full-time) to deny the appeal.⁹⁹ As in *Abram*, the plan did not provide the relevant documentation of the appeal-level opinion to the claimant before denying his appeal.¹⁰⁰ The *Lammers* court acknowledged the ambiguities in *Abram* in attempting to apply it to the instant case:¹⁰¹

Abram is a relatively recent opinion, and its precise scope is far from clear. But *Abram* seems to require that, if the plan administrator solicits a medical opinion at any time during the proceedings—including during an appeal—the claimant must be informed of that medical opinion and given a meaningful opportunity to respond to it before the final decision is reached.¹⁰²

On this ground, the court held that the plan denied *Lammers* his right to a full and fair review.¹⁰³

However, the *Lammers* court did not come to its conclusion without addressing the defendant's reliance on *Metzger*.¹⁰⁴ The court stated that

[i]n *Metzger*, the court held that an ERISA plan was not required to disclose an appeal-level physician report to a claimant prior to the plan's final benefit decision, because to do so would create a lengthy cycle of submission and review, prolonging the appeals process. Inefficiency concerns, however, cannot surmount ERISA's full and fair review mandate.¹⁰⁵

This emphasis on the inherent full and fair review requirements demonstrates the court's belief that the regulations relied upon in *Metzger* should not control. The district court went on to clarify this distinction and ultimately sided with *Abram*'s analysis:

Moreover, the Court rejects *Metzger*'s attempt to distinguish *Abram*. In *Metzger*, the court reasoned that 29 C.F.R. § 2560.503-1, a Department of Labor regulation regarding "full and fair review," had been amended to indicate that an ERISA plan must only provide an employee with documents generated during the initial claim denial, not during the appeal stage. The *Metzger* court held that, because *Abram* filed her claim before the regulatory amendment was effective, the *Abram* decision was not persuasive. *Abram*, however, was rooted in ERISA's fundamental "full and fair review" requirement, 29 U.S.C. § 1133(2), and ERISA's core goal of facilitating a fair dialogue between plan and claimant, both of

99. *Id.* at *4.

100. *Id.*; *Abram*, 395 F.3d at 885.

101. *Lammers*, 2007 WL 2247594, at *2.

102. *Id.*

103. *Id.* at *5.

104. *Id.* at *6.

105. *Id.* (citation omitted).

which have remained constant, not on an interpretation of 29 C.F.R. § 2560.503-1.¹⁰⁶

Even if the regulations control, the *Lammers* court believed that the *Metzger* court interpreted them incorrectly.¹⁰⁷ The *Lammers* court stated that

the regulatory language upon which *Metzger* relies, 29 C.F.R. § 2560.503-1(m)(8), requires a plan to disclose documents used in making the "benefit determination." The regulation's plain language, therefore, is not narrowly confined to the initial benefit determination, as *Metzger* improperly concludes, but rather requires ERISA plans to disclose relevant documents during any phase of the "benefit determination," including at the appeal level.¹⁰⁸

The district court in *Lammers* therefore declared *Metzger* to be incorrect on multiple levels, providing a much starker contrast than the Eighth Circuit offered in *Abram*.

Finally, the *Lammers* court took one extra step to ensure that the "circularity of review" issue in *Metzger* would not hamstring the *Abram* holding.¹⁰⁹ It stated:

To be clear: The Court does not understand *Abram* to require that *Lammers* be given an opportunity to submit new medical evidence in response to the new reports. If claimants had such a right, the result would be an endless cycle in which each new medical opinion solicited by the plan administrator would be met by new medical evidence submitted by the claimant that would have to be the subject of yet another medical opinion solicited by the plan administrator that would then be met by yet more medical evidence submitted by the claimant. The plan administrator must be able to close the evidentiary record at some point Thus, although *Lammers* must be given an opportunity to respond [to the opinions relied upon in the initial denial], *Abram* does not give *Lammers* the right to respond with new medical evidence.¹¹⁰

While this effectively avoids one of the chief concerns in *Metzger*, the *Lammers* court's approach is hard to reconcile with the requirements of a full and fair review.¹¹¹ The opportunity to view appeal-level documents lacks any significant meaning in the context of a full and fair review if the claimant has no opportunity to respond with medical evidence.¹¹²

106. *Id.* (citation omitted).

107. *Id.*

108. *Id.*

109. *Id.* at *2.

110. *Id.*

111. *But see* Glazer v. Reliance Standard Life Ins. Co., 524 F.3d 1241, 1245–46 (11th Cir. 2008) (adopting the *Metzger* approach of not requiring access to appeal-level documents).

112. *See* discussion *infra* Part VI.A.

B. The Ninth Circuit: The Additional Novel Ground in *Abatie* Requires the Same Document Access as the Alternate Novel Ground in *Abram*

The *Abatie* case contains a level of nuance in its reasoning that is absent in both *Metzger* and *Abram*. In the latter cases, the plan relied on the same theory as the original denial in one case and a novel theory in the other, respectively.¹¹³ The issue in *Abatie* was the plan's "tacking on" of a novel ground for denial upon one that was already disclosed in the initial denial.¹¹⁴

In other words, the Eighth Circuit held that a plan fails to provide a full and fair review if it initially denies a claim for reason A, then denies the appeal for reason B without first notifying the participant and allowing him to review and respond.¹¹⁵ The Tenth Circuit held that a plan *does not* fail to provide a full and fair review if it denies the appeal for reason A (the same as the initial denial) without providing the participant access to new appeal-level documentation supporting the denial beforehand.¹¹⁶ The question in *Abatie* was whether a plan fails to provide a full and fair review when it denies the appeal for reason A *and* B without first notifying the participant and allowing him to review and respond to B.¹¹⁷ According to the Ninth Circuit, tacking on a new ground onto the appellate denial violates the plan participant's right to a full and fair review.¹¹⁸

As in *Abram*, the Ninth Circuit was careful to circumscribe the reach of its ruling. The court stated that "an administrator that adds, in its final decision, a new reason for denial, a maneuver that has the effect of insulating the rationale from review, contravenes the purpose of ERISA."¹¹⁹ Again, there is nothing to suggest that the opinion requires plans to *always* give the participant access to appeal-level reports and therefore nothing to suggest that the Ninth Circuit's holding was inconsistent with the rulings of the Eighth and Tenth Circuits.

113. See *Metzger v. UNUM Life Ins. Co. of Am.*, 476 F.3d 1161, 1163 (10th Cir. 2007); *Abram v. Cargill, Inc.*, 395 F.3d 882, 885 (8th Cir. 2005).

114. *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 974 (9th Cir. 2006).

115. See *Abram*, 395 F.3d at 885.

116. See *Metzger*, 476 F.3d at 1163.

117. See *Abatie*, 458 F.3d at 974.

118. *Id.*

119. *Id.*

C. The Muddled State of the Law in the Wake of These Appellate Decisions

A careful reading of the cases analyzed above reveals two general principles that a plan in any of the three circuits should abide by.

First, if the plan is going to deny an appeal based on new facts or a novel theory (in whole or in part), including tacking on an additional new theory to the original, it should provide the participant access to the relevant documents before the final denial. It is arguable that the Tenth Circuit does not require such access because of its ruling in *Metzger*.¹²⁰ However, because the court is careful in one sentence to limit its holding to cases that do not involve novel grounds for denial,¹²¹ plans cannot safely rely on a bright-line rule that does not require access.

Second, if the plan does not rely on a novel theory in its final denial, full and fair review may not require that the plan provide the participant access to appeal-level documents before the final denial. Because the Eighth and Ninth Circuit cases involved new grounds for denial on appeal and appear to limit their holdings to such situations, they may not require access in a fact pattern similar to that of *Metzger* (where there is no novel ground on appeal). In the Tenth Circuit, plans can safely refrain from providing access when there is no new ground for denial.

Thus, the law in this area remains unsettled by the conflicting decisions from the Eighth, Ninth, and Tenth Circuits.

IV. Three Major Problems with the Current Regulations and Courts' Interpretations of Them

The Eighth, Ninth, and Tenth Circuit Courts appear to have narrowly tailored their opinions to the facts of the cases before them.¹²² None of the three courts even attempted in dicta to clearly state what the broader "full and fair review" requirements are in the appeal-level document context. This is unfortunate because of the confusion the three opinions have created in an area that is already dauntingly com-

120. *Metzger*, 476 F.3d at 1167.

121. See *supra* Part II.C.1 (discussing the Tenth Circuit's holding in *Metzger* that as long as appeal-level reports contain no new factual information or novel diagnoses, two-phase disclosure is consistent with full and fair review).

122. See *Metzger*, 476 F.3d at 1167; *Abatie*, 458 F.3d at 974; *Abram v. Cargill, Inc.*, 395 F.3d 882, 886 (8th Cir. 2005).

plex.¹²³ By carefully couching exceptions to their holdings, none of the opinions establish a bright-line rule to assist plan administrators.¹²⁴ Instead, three problems emerge. First, the current regulations and courts' interpretations of them are not in the best interest of either party in an ERISA benefits appeal because of issues related to the timing of when claimants are given access to appeal-level documents. Second, the law as it stands is inconsistent with the DOL's stated intent.¹²⁵ Lastly, plans now must conduct a difficult analysis of how their denied appeal will compare to their initial denial, and in some cases, provide documents before the final determination to ensure compliance with full and fair review.¹²⁶

A. Requiring Access to Appeal-Level Documents May Lead to Delays for the Participant and Extra Costs for Plans

The appeal process is designed to last forty-five or sixty days.¹²⁷ If plans are required to provide the participant access to appeal-level documents during the course of an appeal, the rationale must be to allow the participant to review and respond to those new documents. Such access could logically serve no other function since the regulations clearly require that the participant be provided access to appeal-level documents upon final denial of an appeal.¹²⁸ Thus, any rule or decision allowing participants earlier access to those documents must be designed to give them an opportunity to respond before a final decision is made.

Whenever a plan is required to provide documents during the appeal, however, the forty-five or sixty-day time frame may be compromised by the extra time needed for the participant to rebut. *Metzger*

123. See, e.g., *Niles v. Am. Airlines, Inc.*, No. 04-4060, 2007 WL 30607, at *12 (D. Kan. Jan. 3, 2007) (demonstrating the general confusion that district courts face under the current law); *Hornback v. N.Y. Times Co. Long Term Disability Plan*, No. 05-00508, 2006 WL 496050, at *10 (N.D. Cal. Mar. 1, 2006) (same); *Harris v. Aetna Life Ins. Co.*, 379 F. Supp. 2d 1366, 1371-74 (N.D. Ga. 2005) (same).

124. See *Metzger*, 476 F.3d at 1167 ("So long as appeal-level reports analyze evidence already known to the claimant and contain *no new factual information or novel diagnoses*, this two-phase disclosure is consistent with 'full and fair review.'" (emphasis added)); *Abatie*, 458 F.3d at 974 ("[A]n administrator that adds, in its final decision, a *new reason* for denial . . . contravenes the purpose of ERISA." (emphasis added)); *Abram*, 395 F.3d at 886 ("A claimant is caught off guard when *new information* used by the appeals committee emerges only with the final denial." (emphasis added)).

125. See discussion *infra* Part IV.B.

126. See *Abatie*, 458 F.3d at 974; *Abram*, 395 F.3d at 886; see also *Metzger*, 476 F.3d at 1167.

127. See ERISA Claims Procedure Rule, 29 C.F.R. § 2560.503-1(i)(1)(i), 1(i)(3)(i) (2007).

128. *Id.* § 2560.503-1(i)(5).

touches on this issue primarily in its concern about circularity (i.e., an endless loop of submissions and rebuttals).¹²⁹ But if a plan is required to provide access to documents during the appeal, such as in the *Abram* and *Abatie* decisions,¹³⁰ the plan has no guidance as to *when* it must provide such access. Even if the plan does provide the participant a reasonable time to rebut, the participant could simply wait until the last minute to provide his evidence in response.

A participant's rebuttal in the final days of an appeal period could lead to two unfortunate results. On one hand, the plan may simply be unable to consider the appellant's response within the time frame mandated by the regulations for its determination and therefore be forced to make a decision without taking into account the participant's rebuttal. A regulatory system that allows this to frequently occur is absurd since it would negate the reason for granting the participant access to the document in the first place. It would also violate section (h)(3)(iii),¹³¹ assuming *Metzger's* interpretation of the regulation is correct, for failure to have a medical professional evaluate the evidence.¹³² Furthermore, if the rebuttal evidence might sway the plan's determination, the plan's adherence to the time deadline instead of carefully considering the evidence could force the plan to deny the appeal when it otherwise would not. The participant would then have to unnecessarily expend time and money seeking counsel and bringing an action in district court, undermining the value and purpose of the administrative appellate structure.¹³³ This would also further delay the participant's access to benefits and possibly put the plan in an unfair position when sued for not having considered the participant's potentially authoritative rebuttal.

Alternatively, the plan may invoke the special circumstances clause of section (i)(1)(i).¹³⁴ This section provides that the forty-five or sixty-day limit applies "unless the plan administrator determines

129. *Metzger*, 476 F.3d at 1166-67.

130. *Abram*, 395 F.3d at 886; *Abatie*, 458 F.3d at 974.

131. 29 C.F.R. § 2560.503-1(h)(3)(iii).

132. *Metzger*, 476 F.3d at 1166.

133. For instance:

The Department is committed to ensuring that participants and beneficiaries are afforded fair and timely reviews of their benefit claims. At the same time, the Department recognizes that an orderly, efficient, and cost-effective implementation of the claims procedure rules by group health plans will ultimately benefit all affected parties, including plan participants and beneficiaries.

ERISA Claims Procedure, 66 Fed. Reg. 35,886, 35,886 (July 9, 2001) (codified at 29 C.F.R. pt. 2560).

134. 29 C.F.R. § 2560.503-1(i)(1)(i), (i)(3)(i).

that special circumstances . . . require an extension of time for processing the claim [which must be no longer than an additional forty-five or sixty days].”¹³⁵ Exercising this option would allow the plan to drag the administrative process along to the detriment of the participant. In many cases, it will only delay the plan’s inevitably unfavorable determination and force the participant to wait even longer to bring an action. In theory, the extension may allow the plan to fully review the rebuttal evidence, approve the claim, and save both parties the expense of litigation. Unfortunately, the likelihood of this ideal result is heavily outweighed by the potential for abuse.¹³⁶

B. All Three Circuits Fail to Comply with the Department of Labor’s Intent

Metzger’s strongest argument against allowing participants access to documents during the appeal is that it would contravene the DOL’s intent in creating the amended regulations. The DOL stated its reason for the addition of 29 C.F.R. § 2560.503-1(m)(8) was to define relevant documents for full and fair review in terms of a final denial:

As a concomitant to this general requirement, subparagraph (m)(8)(iii) further provides that, among the information that a plan must provide a claimant upon request *after receiving an adverse benefit determination*, is any information that the plan has generated or obtained in the process of ensuring and verifying that, in making the particular determination, the plan complied with its own administrative processes and safeguards that ensure and verify appropriately consistent decisionmaking [sic] in accordance with the plan’s terms.

....

135. *Id.*

136. See, e.g., *Donnell v. Metro. Life Ins. Co.*, 165 F. App’x 288, 297 (4th Cir. 2006) (holding that a plan that fails to meet the outer time limit, even after invoking the extension, will not constitute an abuse of the plan’s discretion unless there is a causal connection between the failure to meet the time limit and the final denial of the claim); *Soltysiak v. Unum Provident Corp.*, No. 05-148, 2006 WL 2884461, at *3 (W.D. Mich. Oct. 10, 2006) (holding that the arbitrary and capricious standard of review, which is “‘extremely deferential’” and “‘the least demanding form of judicial review,’” applies even when a plan fails to meet the extension deadline (quoting *McDonald v. Western-Southern Life Ins. Co.*, 347 F.3d 161, 172 (6th Cir. 2003))); *Seitz v. Metro. Life Ins. Co.*, No. 04-1003, 2005 WL 715932, at *17 (N.D. Iowa Mar. 30, 2005), *rev’d on other grounds*, 433 F.3d 647 (8th Cir. 2006) (holding that the court will infer abuse of a plan’s discretion for failure to meet the extension deadline only when the irregularity is “‘so egregious that the court has a total lack of faith in the integrity of the decision making process’” (quoting *Tillery v. Hoffman Enclosures, Inc.*, 280 F.3d 1192, 1199 (8th Cir. 2002))). But see *Jebian v. Hewlett-Packard Co. Employee Benefits Org. Income Prot. Plan*, 349 F.3d 1098, 1103 (9th Cir. 2003) (applying the *de novo* standard where a plan deems a claim denied after the expiration of a certain time period).

The Department believes that this specification of the scope of the required disclosure of "relevant" documents will serve the interests of both claimants and plans by providing clarity as to plans' disclosure obligations, while providing claimants with adequate access to the information necessary to determine whether to pursue further appeal.¹³⁷

The DOL's stated intent demonstrates that its concept of "full and fair review" applies to the initial denial.¹³⁸ The participant is entitled to a full and fair review of the information and evidence that led the plan to deny the claim.¹³⁹ If new information is discovered during the appeal, the plan should have the right to use it against the participant in creating a new theory.¹⁴⁰ When the appeal is denied, the participant should be provided the relevant documents that the plan relied on in bringing its novel theory.¹⁴¹ The participant can then review these documents and determine whether to pursue an appeal by filing a claim in district court.¹⁴²

The Eighth and Ninth Circuits likely viewed the DOL's above-quoted intent not as an exhaustive coverage of when plans must provide a participant access, but merely one instance where it is applicable.¹⁴³ The fact that plans must provide access following a denial does not foreclose the possibility of access being required at an earlier time. But in such a highly regulated field, there ought to be a presumption that the lack of a regulation directing access during the course of an appeal is significant. If the DOL intended to require access to documents under any circumstance, during the course of an appeal, why would its regulations only explicitly require access to documents at the outset and completion?¹⁴⁴

137. ERISA Claims Procedure, 65 Fed. Reg. 70,246, 70,252 (Nov. 21, 2000) (codified at 29 C.F.R. pt. 2560) (emphasis added).

138. *Id.*

139. *Id.*

140. *Id.*

141. *Id.*

142. *Id.*

143. See *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 974 (9th Cir. 2006); *Abram v. Cargill, Inc.*, 395 F.3d 882, 886 (8th Cir. 2005).

144. See *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 209 (2002) ("We have observed repeatedly that ERISA is a 'comprehensive and reticulated statute'" (quoting *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 251 (1993))); see also *Transamerica Mortgage Advisors, Inc. v. Lewis*, 444 U.S. 11, 19 (1979) ("[I]t is an elemental canon of statutory construction that where a statute expressly provides a particular remedy or remedies, a court must be chary of reading others into it."); *Botany Worsted Mills v. United States*, 278 U.S. 282, 289 (1929) ("When a statute limits a thing to be done in a particular mode, it includes the negative of any other mode.").

Despite the Tenth Circuit's attempt in *Metzger* to analyze and comply with the DOL's stated intent, it also fails. The *Metzger* court leaves a gaping exception by failing to distinguish the case presented with differing factual situations, as illustrated by the cases from the Eighth and Ninth Circuits.¹⁴⁵ By declining to create a bright-line rule against requiring access to appeal-level documents, the court left the door open for requiring access in factual situations more similar to *Abram* and *Abatie*, which again contravenes the DOL's intent.

C. Determining Whether the Plan Relied on a Novel Ground

All three circuits appear to ground their holdings on whether the plan relied on the appeal-level documents in creating a new reason for denying the claim on appeal.¹⁴⁶ This is problematic, even when the plan indisputably changes its basis for denial on appeal, because it contradicts the DOL's intent¹⁴⁷ and creates the potential for time delays and additional expenses. But placing such crucial significance on whether the plan relied on a novel ground may in itself cause problems by forcing litigation to focus entirely on this ancillary issue.

For instance, what if a plan only slightly changes its reasoning in denying an appeal? Will courts have to develop a rule that determines whether the change is substantial or material? And if so, how much time and money will be wasted litigating that point? Furthermore, courts will be forced to determine whether they agree with the *Abatie* holding, which implied that tacking on an additional ground constitutes a novel ground for document access purposes.¹⁴⁸

Any focus on a plan's altered grounds for denial also opens the door for plans to abuse the system. Plans might regularly decide not to change their grounds for denying a participant's claim on appeal to avoid having to provide document access to the participant and to save the cost of addressing the participant's rebuttal evidence. Alternatively, plans may regularly, and without cause, change their grounds on appeal in order to invoke the special circumstances time exten-

145. See discussion *supra* Part II.C.1 ("So long as appeal-level reports analyze evidence already known to the claimant and contain no new factual information or novel diagnoses, this two-phase disclosure [at the outset and conclusion of the appeal] is consistent with 'full and fair review.'" (quoting *Metzger v. UNUM Life Ins. Co. of Am.*, 476 F.3d 1161, 1167 (10th Cir. 2007))).

146. See *Metzger*, 476 F.3d at 1167; *Abatie*, 458 F.3d at 974; *Abram*, 395 F.3d at 886.

147. ERISA Claims Procedure, 65 Fed. Reg. 70,246, 70,252 (Nov. 21, 2000) (codified at 29 C.F.R. pt. 2560) ("[A] plan must provide a claimant upon request after receiving an adverse benefit determination . . .").

148. *Abatie*, 458 F.3d at 974.

sion, thereby delaying payment on claims as long as possible. This would undermine the regulatory intent to limit the extension to special circumstances.¹⁴⁹ Thus, this final problem highlights the need for a clear and concise approach to handling access to appeal-level documents during the appeals to decisions of ERISA claims for benefits.

V. A Suggested Regulation That Does Not *Require* Access to Appeal-Level Documents but Creates an *Incentive* for Plans to Provide Access

The proposed amendment would add a new regulation to clarify that full and fair review does not require that plans provide access to appeal-level documents during the course of an administrative appeal. It attempts to do so in a manner that benefits both plans and plan participants.

A. Proposed Amendment: A Bright-Line Rule

The ERISA Claims Procedure Rule, 29 C.F.R. § 2560.503-1(i)(2), requires that plans provide the claimant with all documents relied upon for review following an adverse determination.¹⁵⁰ The suggested amendment adds a new subparagraph foreclosing any interpretation of full and fair review to require access during an appeal. However, it creates an incentive for plans to provide documents to promote plan disclosure and participant access in the spirit of the plain meaning of full and fair review. The suggested regulation also creates the necessary procedural framework to ensure that appeal-level access operates efficiently and without undue burden on either party.

SUGGESTED REGULATION 29 C.F.R. § 2560.503-1(i)(5)(i):¹⁵¹

The plan is not required to provide the claimant access to documents generated during the course of the appeal before making a final determination.

However, if the plan denies an appeal by relying, in whole or in part,¹⁵² on a novel theory or facts not considered in the original denial of the claim and does not provide the claimant access to the documents setting out such a novel theory or new facts at least 15

149. ERISA Claims Procedure Rule, 29 C.F.R. § 2560.503-1(i)(1)(i) (2007).

150. *Id.* § 2560.503-1(i)(2).

151. Currently there is no regulation labeled 29 C.F.R. § 2560.503-1(i)(5)(i). This proposed codification is designed to immediately follow 29 C.F.R. § 2560.503-1(i)(5), which regulates the furnishing of documents. *Id.* § 2560.503-1(i)(5); *see also* discussion *supra* Part I.

152. The Federal Register should note that the Department of Labor intends for the phrase "in whole or in part" to cover the tacking on of an additional ground, as in *Abatie*, 458 F.3d at 974.

days before denying the appeal (no later than the 30-day mark for a disability claim or the 45-day mark for any other welfare plan claim), the plan, if sued by the claimant following denial of the appeal, will have to overcome a rebuttable presumption that the documents were intentionally withheld to deny the claimant a full and fair review. The plan can overcome this presumption by demonstrating that it acted reasonably and in good faith.

If the claimant, after receiving documents setting out a novel theory or new facts during the appeal, then submits new medical evidence as a rebuttal to those documents within the applicable appellate time frame[two words], the plan will have twenty extra days (no later than the 65-day mark for a disability claim or the 80-day mark for any other welfare plan claim) to consider the rebuttal evidence and make its determination of the appeal. This 20-day extension will operate to the exclusion of paragraph (i)(1)(i).¹⁵³ The claimant has no right to access or rebut documents generated by the plan during the course of this 20-day extension. The plan shall provide such documentation upon an adverse determination.

Paragraph (i)(5)(i) shall not apply to paragraph (i)(2).¹⁵⁴

B. The Proposed Regulation Will Benefit Both Plans and Participants

Plan participants might assume that requiring access to appeal-level documents during an appeal would only benefit them, but the right to a “full and fair review” cannot be viewed in isolation. In light of the larger regulatory scheme and its effects, as described in Part VI, participants should also be concerned that such access would delay the administrative process and ultimately act to their detriment. Although such a delay may, in some cases, benefit participants by allowing them to successfully rebut the plan’s new evidence and win their appeals, thereby avoiding the delay and the costs of litigation, in many cases the added time would only postpone an inevitable denial.¹⁵⁵

Similarly, while plans may have the opportunity to delay payment of expensive benefit claims, the proposed rule will not work to their

153. 29 C.F.R. § 2560.503-1(i)(1)(i), (i)(3)(i), provides for special circumstances by extending the appeals process forty-five days for a disability claim and forty-five days for any other welfare plan claim. *Id.*

154. 29 C.F.R. § 2560.503-1(i)(2) provides review procedures for group health plans, including different deadlines for pre- and post-service claims, as well as the option to provide two levels of appeals with shorter deadlines. *Id.* The suggested regulation could be modified to apply to group health plans under paragraph (1)(2), but that possibility is beyond the scope of this Comment.

155. See Carole Roan Gresenz et al., *Patients in Conflict with Managed Care: A Profile of Appeals in Two HMOs*, 21 HEALTH AFF. 189, 194 (2002), for an analysis of the appeals process detailing participants’ appeal success rate at two major plans.

exclusive benefit either.¹⁵⁶ The proposed regulation adds administrative requirements that are likely to be expensive.¹⁵⁷ Also, the cost of determining whether the participant is entitled to new documents, along with the cost of addressing participants' rebuttal evidence, is likely to be significant.¹⁵⁸

A rule that requires more administrative processes in an already highly regulated procedure will be detrimental to both plans and participants.¹⁵⁹ The DOL did not intend to require access to documents during appeal,¹⁶⁰ plans almost certainly do not want to be forced to provide such access, and participants are not necessarily benefited by such access since it will create delays arising from their new responsibility to rebut appeal-level arguments. Therefore, the DOL should eliminate this confusion in its next set of amendments by drafting a regulation, such as the one suggested above, which explicitly requires access only upon final denial of an appeal.

This proposed amendment will create an incentive, but not a requirement, for plans to provide the participant access to documents during an appeal. Like a shareholder vote or approval by a disinterested board committee in corporate law,¹⁶¹ providing the documents would grant the plan a safe harbor. In the situations where it is not feasible or beneficial for the plan to provide access to appeal-level documents, the plan would have to rebut the presumption that it in-

156. In fact, it will likely be of greater benefit to the participant. See discussion *infra* Part VI.D.

157. See, e.g., Steffie Woolhandler et al., *Costs of Health Care Administration in the United States and Canada*, 349 NEW ENG. J. MED. 768, 769 (2003) (demonstrating that health plans in the United States already spend approximately three times more on administrative costs than health plans in Canada).

158. See generally James G. Kahn et al., *The Cost of Health Insurance Administration in California: Estimates for Insurers, Physicians, and Hospitals*, 24 HEALTH AFF. 1629 (2005) (discussing the administrative costs of health plans in California); MARK E. LITOW, MEDICARE VERSUS PRIVATE HEALTH INSURANCE: THE COST OF ADMINISTRATION (2006), available at http://www.cahi.org/cahi_contents/resources/pdf/CAHIMedicareTechnicalPaper.pdf (demonstrating that private health plans spend more on administrative costs than Medicare).

159. See generally Kahn et al., *supra* note 158, at 1629 (discussing the problems with excessive administrative costs).

160. ERISA Claims Procedure, 65 Fed. Reg. 70,246, 70,252 (Nov. 21, 2000) (codified at 29 C.F.R. pt. 2560).

161. See generally *Benihana of Tokyo, Inc. v. Benihana, Inc.*, 906 A.2d 114, 120 (Del. 2006) ("Section 144 of the Delaware General Corporation Law provides a safe harbor . . . [where] 'the board . . . in good faith authorizes the contract or transaction by the affirmative votes of a majority of the disinterested directors . . .'" (quoting DEL. CODE ANN. tit. 8, § 144(a) (2008))); *Marciano v. Nakash*, 535 A.2d 400, 405 n.3 (Del. 1987) ("[A]pproval by fully-informed disinterested directors under section 144(a)(1), or disinterested stockholders under section 144(a)(2), permits invocation of the business judgment rule . . .").

tentionally withheld documents by showing that it acted reasonably and in good faith. Thus, the rule is designed to encourage access in the spirit of full and fair review while avoiding the costly detriments to both sides that may result from a more rigid rule.

VI. The Effect of the Proposed Regulation

Claimants will benefit from the proposed amendment to the CFR in three ways. First, claimants will be able to react to documents and challenge them within the appellate time frame. Second, the plan will have an incentive to act more quickly. Finally, claimants will benefit from an early indication of the plan's reaction to the participant's evidence on appeal.

A. Claimants Will Be Able to Rebut Appeal-Level Documents Within the Appellate Period

The primary purpose of the proposed regulation, and its most significant potential achievement, is that it would provide a meaningful appeals process for the claimant. In *Lammers*, the court held that the claimant was entitled to access documents during the appeal, but not the opportunity to rebut with new medical evidence.¹⁶² The court reasoned that the plan must be able to close the evidentiary record to avoid an endless cycle of submissions.¹⁶³ However, the inherent concept of full and fair review requires that claimants at least have some chance of arguing the merits of their claims during the appeals period.¹⁶⁴ Not allowing claimants to submit new medical evidence would hamstring their ability to rebut the novel theory or evidence on appeal and greatly diminish the value of the document access.

Under the proposed regulation, if a document the plan relies on is false, misguided, or simply states the need for more information (as in *Abram*),¹⁶⁵ the claimant will have at least fifteen days to point out the error *and* rebut it with new medical evidence before the appeal is decided. This will ensure a meaningful administrative appeals process and have the added benefit of reducing the parties' dependence on the federal judicial system since the administrative remedy will func-

162. *Lammers v. Am. Express Long Term Disability Benefit Plan*, No. 06-CV-1099, 2007 WL 2247594, at *2 (D. Minn. Aug. 2, 2007).

163. *Id.*

164. See ERISA Claims Procedure, 42 Fed. Reg. 27,426, 27,426 (May 27, 1977) ("As part of the review the participant must be allowed to see all plan documents and other papers which affect the claim. The participant must be allowed to argue against the denial . . .").

165. *Abram v. Cargill, Inc.*, 395 F.3d 882, 886 (8th Cir. 2005).

tion more effectively to resolve the claim. Furthermore, it will not suffer from the possibility of an endless cycle of submissions as feared in *Metzger* and *Lammers* because the rebuttal will be the claimant's final chance to submit new medical evidence, and the plan will have a fixed twenty day period to review it.¹⁶⁶

To provide a full and fair review, the rule's incentive structure should be strong enough that plans will provide participants with access to appeal-level documents during the course of the appeal in most cases in which the plan relies on a novel ground.¹⁶⁷ In the cases in which the plan does not rely on such a ground, both parties will benefit from an explicit rule not requiring disclosure because the plan will be able to make a final decision within the appellate period.

When a plan does not become aware of the grounds to deny an appeal until it is too late to provide the relevant documents to the claimant (at least fifteen days in advance of the determination), the outer time limit (forty-five or sixty days) remains in place. Plans will not be forced to provide extra time for the participant to rebut the late-arriving evidence or face liability for not giving the participant access, and participants will not be forced to deal with impossibly short time frames or time extensions that will delay their ability to bring an action in federal court. The suggested structure will allow a claimant to quickly take a claim to court under all circumstances and with the added aid of the plan having to overcome an adverse presumption.

B. Claimants and Plans Will Benefit from an Expedited Appeals Process

The proposed regulation will encourage plans to make appellate decisions more quickly. By generating the documents necessary to deny the appeal at least fifteen days before making a determination and concurrently passing those documents on to the claimant, plans will immunize themselves from liability for failing to give a full and fair review. This access will be the greatest advantage of the new rule for the claimant because the documents will provide not only the requisite information to rebut if appropriate but also an invaluable insight into the plan's forthcoming decision.

166. See *Metzger v. UNUM Life Ins. Co. of Am.*, 476 F.3d 1161, 1166 (10th Cir. 2007); *Lammers*, 2007 WL 2247594, at *2.

167. See 42 Fed. Reg. at 27,426.

During the course of an appeal, if a plan generates a novel document that is highly unfavorable to the claimant, the plan is likely to rely on it in denying the appeal. Plans may still need time to analyze the situation before making a final determination, and they will have at least twenty days to do so if they opt to take advantage of the regulation's safe harbor.

C. Claimants Will Receive an Earlier Notification of the Plan's Intent

Under the proposed regulation, the claimant will also get invaluable insight into the plan's forthcoming decision. Assuming some plans will always wait until the appellate deadline to maximize profits, which is generally unavoidable in a system of deadlines,¹⁶⁸ claimants will often be able to see the plan's hand fifteen days earlier than the current regulations require.

Where the claimant receives appeal-level documents during the course of the appeal, and these documents provide a legitimate and indisputable basis for denying the appeal, the claimant likely will have effectively received his or her determination fifteen days before they otherwise might have.¹⁶⁹ This earlier notification may be helpful to a claimant who has an interest in knowing whether the claim will be approved as quickly as possible. For someone who is seeking claim approval to deal with formidable bills, the shortened time frame may help the claimant avoid missing payment deadlines.¹⁷⁰ The advance notice of a looming adverse determination will at least give the claimant the advantage of an earlier opportunity to either secure other funds or contact a lawyer in anticipation of bringing a claim in federal court.

It should also be clear that although the rebuttable presumption will be a hurdle for plans when they do not meet the fifteen-day safe harbor deadline, it will not be so high as to substantially disrupt the careful balance between the interests of the plan and the participant. The plan will have to overcome an adverse presumption by showing

168. For example, the ERISA Claims Procedure Rule, 29 C.F.R. § 2560.503-1(i)(1)(i) (2007), states that decisions should be made within a reasonable time, establishing deadlines only as an outer barrier. However, the outer deadline (sixty days for most welfare plan claim appeals) sets the only hard time frame to discuss with regard to the proposed regulatory amendment. An alternative amendment might seek greater reliance on a reasonableness clause. Any such reliance, however, would place an incredibly difficult burden on a claimant to determine how a plan acted behind closed doors.

169. See discussion *supra* note 168.

170. See discussion *supra* note 168.

that some part of the administrative appeals process made it difficult to provide the reports to the participant within the shortened time frame. The plan must show that it did not intentionally withhold the relevant documents to deny the participant access. This could be done by providing evidence that the plan was unable to determine the novel ground and generate the resulting documentation until it was too late.

That is not to say that the adverse presumption will be easy to overcome. The presumption must be difficult to overcome if the incentive structure is to have teeth. The premise behind the suggested regulation is that the safe harbor should be enticing enough to lure the plans into providing document access to the participants in the vast majority of applicable cases. Plans should find it advantageous to speed up the process and provide the participant access because, given the volume of appeals a plan will be confronted with, it will be less expensive to provide access and ensure immunity than to incur the risk of liability and the costs of litigating even a small number of cases.

D. The Proposed Regulation Tips the Balance Slightly in Favor of Participants' Needs

The suggested approach attempts to strike an appropriate balance between the interests of both plans and participants. However, this approach also recognizes that the overarching statute from which the regulation derives seeks to protect *participants* by guaranteeing "full and fair review" of their claims,¹⁷¹ and therefore the suggested regulation does slightly favor the claimant. Plans may not be pleased by what they perceive as an effective fifteen-day curtailment of the time they have to determine appeals and by the presumption they will face if they fail to provide the relevant documents within the required time frame. They may also object to the expense of consulting with a medical professional once more during the administrative process, as may be required where a participant rebuts appeal-level documents.¹⁷²

171. 29 U.S.C. § 1133(2) (2000).

172. See *Metzger v. UNUM Life Ins. Co. of Am.*, 476 F.3d 1161, 1166 (10th Cir. 2007) ("If plaintiff were allowed to rebut the opinions of professionals consulted at [the administrative appeal] stage, then the layman claims administrator would once again be faced with the possibility of receiving new medical opinions and judgments from plaintiff's experts. Subparagraph (h)(3)(iii) specifically requires such evidence be evaluated by qualified healthcare professionals . . .").

However, the suggested approach is based on the philosophy that it would be safer to err in favor of the participant. Participants face the much more difficult burden of having to fight large, well-funded, and experienced plans, and they also struggle with finding counsel to handle their cases.¹⁷³ Regulations should recognize the uphill struggle that participants face in this situation. At the same time, the courts naturally will be more forgiving of plans if they regularly provide access within the fifteen-day buffer. If plans frequently provide claimants document access, courts will be more likely to believe they have a legitimate reason whenever they do not provide access. These rewards should generally be welcomed by both sides.

E. Two Unresolved Issues: Determining Whether the Plan Relied on a Novel Ground and Lengthening the Administrative Process

One of the problems with the current state of the law is that it puts a heavy emphasis on whether the plan relied on a novel ground to deny an appeal.¹⁷⁴ If the plan does rely on a novel ground, yet does not provide the participant access to the relevant documents that formed its basis for denial, the Eighth and Ninth Circuits will find that the plan violated the participant's right to a full and fair review.¹⁷⁵

The suggested regulation also considers whether or not the plan relied on a novel ground as a factor for denial but does not place the same degree of determinative significance on the issue. In no situation will a plan be held to have denied a full and fair review merely because it relied on a novel ground on appeal without providing the participant access to the relevant documents. Rather, if a plan did rely on a novel ground without providing access, it will have to overcome the presumption that it did so intentionally. If it is unclear whether the plan changed its grounds for denial on appeal, the plan will have a better argument that it did not intentionally withhold documents

173. For example, one attorney whose deceased wife was a participant in an ERISA life insurance plan detailed his struggle to find a lawyer to handle his claim for denial of benefits: "I could not find a lawyer to take the case! . . . The last lawyer who turned me down was the most sympathetic. She said that ERISA is extremely pro-business" MICHAEL H. AGRANOFF, BEWARE OF ERISA (2008), <http://www.agranofflaw.com/bewareoferisa.htm>.

174. See discussion *supra* Part IV.C.

175. See *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 974 (9th Cir. 2006); *Abram v. Cargill, Inc.*, 395 F.3d 882, 886 (8th Cir. 2005); see also *Metzger*, 476 F.3d at 1167 (suggesting that the Tenth Circuit might come to the same conclusion if presented with similar facts).

because it believed the grounds on review to be materially similar to the original.

The proposed regulation could eliminate the novel-ground inquiry entirely, but this result would place added pressure on plans to provide access to participants when such access would be of little or no benefit and may only confuse matters more. The participant's interest in accessing appeal-level documents lies in gaining the ability to rebut the plan's bases for denial during the administrative process. If the documents contain no new reasons for denying the claim, the claimants will have all they need from the evidence provided at the outset of the appeal.

The proposed regulation also has the potential to lengthen the administrative process by twenty days. If a plan provides appeal-level document access to a participant during the course of an appeal, and the participant submits rebuttal evidence before the review period ends, the plan will have an extra twenty days to analyze the rebuttal evidence and come to its conclusion. The added time is designed to recognize the problems plans might face under section (h)(3)(iii),¹⁷⁶ which requires plans to consult a medical professional. The *Metzger* court interpreted this section as requiring a professional consultation for a participant's rebuttal to appeal-level documents.¹⁷⁷ Assuming plans are required to do so, this will take more time. By providing twenty extra days, the regulation will avoid placing plans in the unfair position of not being able to adequately address the rebuttal, which would thwart the administrative process.

While the proposed regulation will, in some instances, add twenty days to the length of the appeal, it will only do so when such a delay is legitimately needed. This delay only applies when a participant submits rebuttal evidence to appeal-level documents. Under the current law, plans are able to add forty-five or sixty days to the length of an appeal to address a similar situation by invoking the special circumstances extension.¹⁷⁸ The proposed regulation eliminates that possibility in favor of the shorter twenty-day time frame. Thus, although participants may have to wait twenty more days for the conclusion of their appeals, that trade-off is offset by the value of an effective appeals process that avoids costly and time-consuming litigation, as well as the avoidance of an even lengthier time extension that the plan could invoke under the current law.

176. ERISA Claims Procedure Rule, 29 C.F.R. § 2560.503-1(h)(3)(iii) (2007).

177. *Metzger*, 476 F.3d at 1166.

178. 29 C.F.R. § 2560.503-1(i)(1)(i), (i)(3)(i) (2007).

F. A New Complication—The Plan's Rebuttal: Demonstrating That It Acted Reasonably and in Good Faith

The proposed regulation requires that if the plan relies on a novel theory on review and does not provide the claimant access to those documents within the fifteen-day buffer, it must show that it did not intentionally withhold documents to deny the claimant his or her right to a full and fair review. To demonstrate this, the plan must show it acted reasonably and in good faith. A potential problem with this requirement is that litigation may be necessary to determine exactly what it means for a plan to act reasonably and in good faith.

However, the proposed regulation is designed with the hope that the interpretation of this provision will rarely be an issue. The plan's incentive to provide access when it will rely on a novel theory should be strong enough to entice plans to do so in the vast majority of cases where it is possible. Where, for example, the plan does not receive the results of its decision until it is too late to notify the participant (between the thirty- and forty-five-day mark in a disability claim and between the forty-five- and sixty-day mark in any other welfare plan claim), the plan should have no trouble demonstrating that it did not intentionally withhold the documents because they were not yet available.

If the plan acquires the documents it will rely on to deny an appeal based on a novel theory before the fifteen-day window, it can provide them to the claimant. If the plan is not able to acquire evidence within the review period, it cannot use such evidence to deny a claim. Therefore, the only situations in which the plan's reasonableness and good faith will be at issue are those where a plan receives the documents within fifteen days of the end of the review period. If the plan argues that it was unable to acquire the documentation for a novel ground until that fifteen-day period before the end of the appellate time frame, the issue will be whether or not it truly was unable to acquire the documents until that time. For the plan to demonstrate that it did not intentionally delay the acquisition of the documents to withhold access to the claimant and thereby intentionally deny the claimant a full and fair review, it will need to have the medical consultant(s), who developed the novel ground for denial and created the applicable documents, testify that the plan acted reasonably and in good faith.

If the medical consultant testifies that the plan delayed in either seeking consultation at the outset or relaying the consultant's documents to the claimant, the plan will not be able to rebut the presump-

tion. If the plan did not inform the medical consultant of the time frame for the claim, or advised the consultant that he or she could wait until the fifteen-day buffer to come to a conclusion, the plan will fail to meet its burden. In all other situations in which the plan acquires the documentation for a novel ground within the fifteen-day buffer time period, the plan should be able to successfully rebut the presumption by demonstrating that it acted reasonably and in good faith.

Conclusion

The law currently provides little guidance on the level of access to appeal-level documents that a claimant is entitled to during an ERISA welfare plan appeals process. To complicate the matter, judges confronting this issue limit their holdings to the precise facts of the case presented. Such holdings may be helpful for future participants and plans in the exact same position and in the same circuit, but under the current law too many appeals will require that both parties infer how to proceed based on dicta and vague notions of what full and fair review means. Compounding the difficulty of understanding the different circuits' approaches to a claimant's right to have access to appeal-level documents, the relevant regulations fail to adequately address this issue. Because of this, the Department of Labor should amend the Code of Federal Regulations to clearly state that plans are not *required* to provide claimants access to appeal-level documents during the course of an appeal. With this proposed addition to the regulations—using a rebuttable presumption to create an incentive for plans to provide access—the process will come closer to achieving the intended meaning of full and fair review.